Response Option Analysis & Planning for Health outcomes

Brussels, 17th April 2018
Why the BNA and ROAP?

In line with the Grand Bargain

- **Goal 3**: Increase the use of **cash-based programming**
  - “Cash cannot meet all needs”
  - Cash “may be complemented by in-kind assistance, specialised interventions, specific technical support and vouchers”

- **Goal 5**: Improve joint and **impartial needs assessments**

- **Goal 6**: include **people** in making the decisions which affect their lives
Situation analysis and ROAP

Situation analysis

1. Needs and vulnerabilities analysis
2. Operational environment analysis

Response Options Analysis & Planning

1. (sector) Response option analysis
   - Sector objectives and target groups
   - Response options appropriateness
   - Cash modalities and mechanisms
   - Response options operational feasibility

2. (inter-sector) Response planning
   - Inter-sector synergies and consistency
   - Cross-sector interventions (MPG)
   - Inter-sector assistance plans
   - Cross-sectoral themes and risk mitigation

Implementation and M&E
**Close-up on situation analysis: sourcing data for the ROAP**

### Focus

**Operational Feasibility & Risk**
- of different modalities of aid delivery:
  - acceptance
  - markets and services functionality
  - organization’s capacities
  - financial service delivery

**Needs**
- of the affected populations, the way they address them and their preferences

### Sources of Information

- National and local authorities
- Market actors and essential service providers (supply of commodities and services)
- Organizations and their staff
- Financial service providers
- Affected populations / Consumers (demand of commodities and services)

### Methods / Tools

- Feasibility assessment (by UNOCHA, WFP, UNICEF, UNHCR)
- Market system overview (under development by ACAPS); UNHCR multi-sector market assessment; RAM; MAG, EMMA; LMA; etc.
- Organizational Capacity Assessment Toolkit (by CaLP); Feasibility assessment (by UNOCHA, WFP, UNICEF, UNHCR)
- UNHCR Cash Delivery Mechanism Assessment Tool (CDMAT); Feasibility assessment
- MPG Consortium basic needs assessment framework & toolkit (under development by SC); Remote Cash Project tool (by NRC)
Example: Sourcing data for the ROAP in Ethiopia

- **October:** Kick-off, stakeholders’ engagement and key decisions
- **November:** Financial Service Provider Assessment
- **December:** Secondary data review; assessment of partner capacity and gov. acceptance
- **January:** Basic Needs Assessment
- **February:** Multi-Sector Market Assessment
- **March:** Feasibility and appropriateness assessments

**Training delivery on the tools & MPG**

**M&E of MPG**

**Response options analysis**

Accountable organisation:
- **All**
- **CaLP**
- **OCHA**
- **DRC**
- **Save the Children**
ROAP Phases

**Phase I (sector level)**

1. Validation of assessment findings and recommendations for report revision
2. Revision of assessment reports
3. Identification and profiling of the most affected groups by district
4. Agreement that lack of purchasing power is among the immediate causes
5. Definition of sector-specific objectives of assistance

**Phase II (sector level)**

1. Identification of response options based on needs and objectives
2. If/when cash is proposed, decide whether applying conditionalities
3. If/when cash is proposed, how much should be transferred
4. If/when cash is proposed, compare available transfer mechanisms
5. Comparative analysis of sector response options
6. Final recommendations on sector response options

**Phase III (inter-sector level)**

1. Presentation of the sector plans and putting together the assistance package by group/location
2. Identification of potential synergies across sectors
3. Agreement on appropriateness of MPG for recurrent expenditures
4. Estimation of MPG value based on recurrent sector expenditures
5. Adjustment of the response options based on agreement of where MPG can be used
6. Consideration of cross-sector themes for selected response options
7. Decision on sectoral one-off transfers, amount and timing
8. Final recommendations
Sector-level outputs of ROAP

- Acknowledgement of situation analysis
- Priority population groups based on severity of needs
- Priority districts based on severity of needs
- Causal analysis and pathways
- Programme objectives for selected districts
- Identification of possible response options, including cash modality(ies); their amounts and transfer mechanisms
- Comparative analysis of response options for each objective and recommendations by group and district
Inter-sector-level outputs of ROAP

- Inter-sector causal analysis at the district level
- Multi-sector response package by group and district
- (Cross-sector) risks including for special needs groups and mitigation measures
- Appropriateness of MPG
- Estimation of value of MPG and other transfers
- Recommended inter-sector programme by group and district
The BNA in Ethiopia

EXAMPLES OF KEY FINDINGS
Severity of healthcare services and commodity needs (source: BNA)
Special needs and negative coping

- 38% of IDP and 37% of resident HHs include pregnant or lactating women.
- When money is tight, 55% of HHs report spending less on medicines and healthcare services than they need to.
- 39% of households have gone without eating for a whole day during the week prior to the survey.
- 1 in 4 IDP HHs have members who are chronically ill, have permanent physical disabilities, mental disabilities, or visual, hearing or speech impediments.
- 64% of individuals in IDP camps are below the age of 18.
- 20% IDP HHs have separated minors.
Why are health needs not met?
Markets and systems of service provision
Preferred assistance modality for health needs

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<th>Babile</th>
<th>Hareshen</th>
<th>Kebribeyah</th>
<th>Tuliguled</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Health commodities</strong></td>
<td>Cash</td>
<td>In kind</td>
<td>Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health services</strong></td>
<td>Cash</td>
<td>In kind</td>
<td>Service</td>
<td></td>
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</table>

Assistance scale: 0.0 - 3.0
Household health expenditures and gap (source: BNA)

<table>
<thead>
<tr>
<th>Category</th>
<th>IDPs</th>
<th>Residents</th>
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<tbody>
<tr>
<td></td>
<td>Self-reported monthly minimum expenditures per HH (from BNA)</td>
<td>Actual monthly health expenditure per HH (from BNA)</td>
</tr>
<tr>
<td>Health products</td>
<td>197 ETB</td>
<td>133 ETB</td>
</tr>
<tr>
<td>Health services</td>
<td>158 ETB</td>
<td>101 ETB</td>
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</tbody>
</table>

Services and essential medicines should be cost free, but in reality households in countries with weak health systems have to shoulder many direct and indirect health costs.
Peculiarities related to health expenditures

- Minimum expenditure basket: used to estimate cash transfer amount
- However, health expenditures relate to individual needs not households’ needs
- Catastrophic events cannot be predicted → not part of AVERAGE expenditure
  - These are extraordinary one-off expenditures
- Needs do not equal expenditures (see below)

- Not possible to control quality of services and commodities available in the market

Basket of basic needs (health, food, shelter, education, etc.)

Expenditure basket

Health-wise, this includes direct and indirect expenditures

This is what people cannot buy with money.

These needs are not monetizable; if they are not met, the problem cannot be resolved by giving cash to vulnerable households.

This is because some of the goods and services that are important to meeting households’ basic needs do not always have competitive markets (e.g. sanitation, education, health & nut)
Part 3: The Health ROAP
Step-by-step process and outputs
So,

- People have health expenditures
- People identify that money is a barrier to buy drugs
- People are able to buy medicines from private pharmacies
- People prefer cash to buy service and medicines

**Most efficient response:** add average amount of cash for health to the MPG?
Inadequate Health Seeking Behavior

Health Needs

Traditional Healers

Lack of Knowledge

Cultural Barriers

Financial Barriers

Loss of Income

Catastrophic Expenditures

Insecurity

Conflict

Non-Functional Health Facilities

Primary Care (CHP & HCs)

Community Services

User Fees

Indirect Costs

Inadequate Availability

Stock-Outs

Inadequate Demand

Increased Demand
Overall objectives for health

- Increased access to quality essential healthcare services (consultation, diagnosis and treatment) to the most vulnerable populations, without suffering financial hardship
- Improved preparedness for acute public health threats
- Strengthen resilience of the health system and communities: NWOW
All health services

If primary and secondary care services are available AND the Woreda has adopted CBHI, OR they apply the Indigent Health Fee Waiver program (which provides the poorest free access to health services), but indigent is higher than 10%, and IDPs

• Expand budget for CBHI and/or MoH Fee waiver budget to cover all indigent/poor
• Enroll IDPs in CBHI
• Contracting with primary care facilities and hospitals to reimburse loss of revenue for waiving user fees
Primary care

If MOH PHCU available but insufficient drugs/supplies:

• Direct supply to PHC facilities
• *Improved rational prescription behaviour*

If MoH PHCU available but insufficient drugs:

• Voucher/contract with selected private pharmacies to reimburse cost of medicines
Secondary care

Available but not able to expand waiving of user fees to increased proportion of poor and IDPs:

• Contracting secondary service providers for complicated referred cases: waive user fee and reimburse costs to the hospital to compensate loss of revenue

• Oversee/monitor quality of care.....
Secondary care

Available but stockouts of medicines and/or medical supplies in MoH hospital

• Contract/vouchers to reimburse cost of drugs/supplies from selected private pharmacies near the hospital

Available but indirect costs for food, transport, accommodation, etc

• Give cash or in-kind to the patients and/or caretakers
Other……

Multipurpose cash targeted to households with health vulnerabilities (HIV/AIDS, TB, NCDs, chronic mental health, PLW, etc)

• Top-up to compensate relatively higher dependency ratios and lower income generating capacity

• Not designed for health expenditures!
New Way of Working

• How can resources be mobilized and pooled from government, humanitarian and/or development sources to finance waiver fee policies and/or subsidizing enrolment in the CBHI for households affected by the crises?
• How can coverage of the CBHI schemes be increased in the areas affected by the crises?
• How can current humanitarian support to availability of medical supplies be done in a way that strengthens the national supply management systems, and/or made more efficient through pooling of funds and centralised purchasing to address absolute shortages?
• How can the functionality of the HEP/HDA be further strengthened in areas affected by the crises to improve access to essential services, screening and referral, and its role in preparedness and response to increased needs?
• How can the existing coordination and policy dialogue platforms further improve interaction between each other?
• How can there be a more systematic process for joint analysis and planning between emergency and development programming?
Feedback on ROAP

• BNA important tool to better understand views of affected population, health seeking and barriers
• Complementarity/overlap BNA-MIRA-HESPER
• ROAP has potential to do more systematic analysis of problems and consider all response options, including cash/vouchers, for HNO/HRP
• Criteria and process for comparing response options too heavy?
• Add health risk analysis and HDN/NWOW
• Give health input to MEB, do our own ’market analysis’
Lessons learned in Ethiopia

• The ROAP should best be facilitated at the district level, engaging experts who are familiar with the specific context

• The work should best be structured in more but shorter working sessions to be spread over a longer period of time

• The ROAP process can be streamlined and simplified for the Task Team by having more work completed by the facilitator

• Facilitation of the ROAP requires at least two persons
<table>
<thead>
<tr>
<th></th>
<th>IDPs</th>
<th>IDPs with special needs</th>
<th>Residents (average household)</th>
<th>Residents with special needs</th>
</tr>
</thead>
</table>
| **Babile**          | • **Food:** Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months  
                      • **Shelter:** One-off unconditional cash transfer for NFI, clothing and emergency shelter within 6 months from displacement  
                      • **Shelter:** One-off commodity voucher to cover the costs of shelter materials and one-off value voucher to cover the costs of shelter construction (labour) within 12 months of start of the project  
                      • **WASH:** Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion  
                      • **WASH:** Direct service to provide community latrines and handwashing facilities | • **Food:** Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months  
                      • **Food:** In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM  
                      • **Shelter:** Direct service provision to improve longer-term shelter solutions (labour + materials) | • **Food:** Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months  
                      • **WASH:** Direct service to provide community latrines and handwashing facilities | • **Food:** Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months  
                      • **Food:** In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM |
DISCUSSION
Questions for discussion

• How does the ROAP (and the BNA) fit within crisis-wide inter-agency needs assessment, analysis and response planning processes?
• How could these linkages be forged and strengthened in the future?
• Who should take ownership of the ROAP?
In Ethiopia, the Humanitarian Disaster Resilience Plan (HDRP) sets national strategic objectives, priority geographic areas (hotspot woredas), number of people to be targeted, funding requirements.

ROAP’s objective is to define programmatic details, by selecting response options that will lead to the achievement of (some of) the objectives set out in the HDRP.

In Ethiopia, the HDRP has national coverage; ROAP focused at the district level.
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